ICF/MR LEVEL OF CARE EVALUATION
FOR INSTITUTIONAL CARE

Applicant Name _____ Age _____ Sex _____

Name of Facility _____ Provider # _____

Diagnosis _____

Admitted From _____

Admissions Orders - (Medications, Diet, Treatments, Therapies, Rehabilitation)

I certify that this resident requires ICF/MR Care.
This resident is free from communicable disease.

_____
Attending Physician's Signature Date

This applicant is limited in three (3) or more of the areas of life activity listed below:

Indicate by placing an X in the appropriate box

☐ **Self Care** (ability to take care of basic life needs for food, hygiene and appearance).

☐ **Receptive and expressive language** (ability to both understand others and to express ideas or information to others either verbally or non-verbally).

☐ **Learning** (ability to acquire new behaviors, perceptions, and information and to apply experiences to new situations).

☐ **Mobility** (ability to ambulate or move from one location to another independently).

☐ **Self-direction** (managing one's social and personal life and ability to make decisions necessary to protect one's self).

☐ **Capacity for independent living** (age-appropriate ability to live without extraordinary assistance, to include maintaining adequate employment and financial support).

Mental Retardation Diagnosis Onset:

☐ Infancy
☐ Developmental (below age 18 years)
☐ Age 18 years and above

IQ Level	Adaptive Functioning Level
☐ MILD	☐ MILD
☐ MODERATE	☐ MODERATE
☐ SEVERE	☐ SEVERE
☐ PROFOUND	☐ PROFOUND

Mental Status

☐ AGITATED ☐ SEVERE DEPRESSION
☐ HALLUCINATES ☐ ABUSIVE

_____
Contact Person

_____
Reviewer